TENNESSEE'S WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

Introduction and Overview

The Tennessee Workers' Compensation Medical Fee Schedule Rules became effective July 1, 2005, pursuant to a mandate from the Tennessee General Assembly as part of the Tennessee Workers' Compensation Reform Act of 2004. *See* Tenn. Code Ann. § 50-6-204(i). The Medical Fee Schedule has undergone several revisions since the first version became effective on July 1, 2005. The current version of the MFS, permanent rulemaking hearing rules, became effective on May 1, 2006. The version effective at the time a medical service is or was rendered is the applicable one for that service.

Our Medical Fee Schedule is made-up of three (3) parts, called chapters, of administrative rules. These three (3) chapters are: Chapter 0800-2-17, 0800-2-18 and 0800-2-19. The first chapter, 0800-2-17, is called the Medical Cost Containment Program Rules. This part contains general information applicable to the other two chapters. It contains most of the definitions used throughout all three chapters, as well as the purpose, scope, general guidelines and procedures. This part explains such things as the basis for the Medical Fee Schedule (Medicare for most of the Medical Fee Schedule), the time-period payers have to timely reimburse providers for undisputed bills, what happens if payers do not comply, and appeal procedures, etc.

The second chapter, Chapter 0800-2-18, is the actual Medical Fee Schedule Rules and addresses such things as the proper conversion factors to use for calculating the maximum allowable amounts for physicians' professional services, depending on the type of service they provide (determined by the classification of the CPT codes), the maximum allowable amounts that may be paid for certain types of medical devices and equipment, such as durable medical equipment and prosthetics and orthotics, penalties for violations of the Medical Fee Schedule, what actually constitutes a violation, etc.

Chapter 0800-2-19, the In-patient Hospital Fee Schedule, sets out how hospitals should be reimbursed. Unlike most of our Medical Fee Schedule, this section, for the most part, is not based on Medicare methods, but reimburses hospitals on a per day or "per diem" basis. This section also contains definitions and procedures specifically applicable to inpatient hospital reimbursements.

These three (3) chapters of administrative rules listed above are referred to collectively as the Tennessee Workers' Compensation Medical Fee Schedule, the Medical Fee Schedule, the Fee Schedule, or MFS.

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I. DEFINITIONS AND REFERENCES

Most definitions needed for proper use of the Tennessee Medical Fee Schedule are provided in the Medical Cost Containment Program Rules, specifically Rule 0800-2-17-.03. These should be consulted thoroughly to familiarize you with the particular meanings of terms used throughout the Medical Fee Schedule and in the Inpatient Hospital Fee Schedule. The definitions and references below are provided as an additional aid in use of the Fee Schedules.

CPT CODE

The Current Procedural Terminology ("CPT") code is obtained from the current edition of the American Medical Association's Current Procedural Terminology. Further information regarding CPT codes is available at the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov/ These codes are available for purchase at various sites on the internet including http://www.ama-assn.org/

DIAGNOSIS CODE

Diagnosis code is the "ICD 9" code which best describes the reason(s) for the procedure, service, supply or encounter. Further information regarding ICD-9 codes is available at the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov/ . These codes are available for purchase at various sites on the internet including http://www.ama-assn.org/

ICD9 PROCEDURE CODE

"ICD 9" means the current edition of the International Classification of Diseases, published by the World Health Organization's (WHO). Further information regarding ICD-9 codes is available at the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov/ These codes are available for purchase at various sites on the internet including http://www.ama-assn.org/

HCPCS CODE

Services and medical supplies must be coded with valid procedure or supply codes of the Health Care Financing Administration Common Procedure Coding System ("HCPCS"). Further information regarding HCPCS is available at the Centers for Medicare and Medicaid Services website at http://www.cms.hhs.gov/ . The codes are available for purchase at various sites on the internet including http://www.ama-assn.org/

NDC CODE

National Drug Code – information is available at the following website.
http://www.fda.gov/cder/ndc/index.htm

CMS means the U.S. Centers for Medicare and Medicaid Services.

U & C means the usual and customary amount, which is 85% of billed charges.

BR (By Report) means the procedure is not assigned a maximum fee and requires a written description. Paid at U & C (85% of billed charges).

CPT means the current edition of the American Medical Association's Current Procedural Terminology.

Independent Medical Examination ("IME") refers to an examination and evaluation conducted by a practitioner different from the practitioner providing care, other than one conducted under the Division's Medical Impairment Rating Registry Program (MIRR). An IME shall be billed at $500.00 per hour and pro-rated per quarter hour. The office visit billed is included with the code and shall not be billed separately. Lab, x-rays, or other tests shall be identified and reimbursed accordingly.

Pattern of Practice means at least one or more violations of the Medical Fee Schedule Rules, the Medical Cost Containment Rules and/or the In-patient Hospital Fee Schedule Rules have occurred after the notice of a violation has been issued from the Department for the first violation.

Preauthorization means the employer or carrier accepts the injured or disabled employee's injury or disease as compensable under the Act and authorizes payment of benefits under the Act. Preauthorization is required for all non-emergency medical services (outpatient and inpatient). Failure to timely communicate (within seven (7) working days) the decision of authorizing or not authorizing the service requested by a medical provider shall result in the authorization being deemed appropriate.

Primary Procedure means the therapeutic procedure most closely related to the principle diagnosis.

Utilization Review means the evaluation of the necessity, appropriateness, efficiency, and equality of medical care standards provided to an injured or disabled employee based on medically accepted standards and an objective evaluation of the medical care services provided; provided that "utilization review" does not include the establishment of approved payment levels or a review of medical bills or fees.
Utilization review providers must be certified by the Tennessee Department of Commerce and Insurance.

All of the above definitions, as well as many others, may be found in Rule 0800-2-17-.03 and should be consulted.

II. GENERAL INFORMATION

Unlike fee schedules in some other states, Tennessee's Medical Fee Schedule does not set an absolute fee for services, but instead, sets a maximum amount that may be paid. Providers and payers are encouraged to negotiate amounts below the maximum set in the Medical Fee Schedule, but shall not pay an amount above the Fee Schedule maximum amount. A payer paying in excess of the Fee Schedules and a provider retaining excessive reimbursement over 90 days is a violation of the Fee Schedule Rules and may result in penalties up to a $10,000.00 civil penalty against both payer and provider, among other measures, based on the Commissioner's (or the Commissioner's Designee's) discretion. *See* Rule 0800-2-18-.02(2)(b)(4.)

The Medical Fee Schedule applies to ***all*** medical services and medical equipment or supplies. Reimbursement to all providers ***shall be the lesser of***: (1) the provider's usual charge, (2) the maximum fee schedule under these Rules, or (3) the MCO/PPO or any other negotiated and contracted amount. *See* Rule 0800-2-18-.02(b). **This lesser of comparison must be done on the total bill or amount due, NOT a line-by-line comparison of items.**

When there is no specific methodology in these Rules for reimbursement, the maximum reimbursement is 100% of Medicare. Whenever there is not Medicare methodology, maximum reimbursement is Usual & Customary or U & C (85% of billed charges). *See* Rule 0800-2-18-.02(a).

Procedure codes for unlisted procedures should only be used when there is no procedure code which accurately describes the services rendered. These codes require a written report and are paid at a maximum allowable amount of usual and customary (85% of billed charges.) *See* Rule 0800-2-17-.06.

Unless otherwise stated in the Rules, the current effective Medicare procedures and guidelines are to be used. *See* Rule 0800-2-18-.02(a).

Relative Value Units ("RVUs") may be obtained from the current edition of the Medicare RBRVS: The Physician's Guide. This should be used in conjunction with the current edition of the AMA's CPT Coding Guide. These books may be obtained by contacting the American Medical Association at **American Medical Association,** 515 N. State Street Chicago, IL 60610, telephone (800) 621-8335, or by visiting the AMA's bookstore online at the American Medical Association's website: www.ama-assn.org .

When extraordinary services resulting from severe head injuries, major burns, severe neurological injuries, or any injury requiring an extended period of intensive care, a greater fee may be allowed up to 150% of the professional service fees normally allowed under these Rules. This provision does not apply to In-patient Hospital facility fees. *See* Rule 0800-2-1.

A. Applicability of the Tennessee Workers' Compensation Medical Fee

The Medical Fee Schedule is applicable to all injured employees, no matter where the injury took place, so long as that person is claiming workers' compensation benefits under Tennessee's workers' compensation law. It is applicable to all medical services for these injured employees based on the date the medical service is received, not on the date of the employee's injury.

See Rule 0800-2-17-.01.

B. The Tennessee Medical Fee Schedule is a "Cap"

Tennessee's Workers' Compensation Medical Fee Schedule sets-out the maximum a provider may be reimbursed. Employers, carriers, and providers may negotiate and contract lesser fees as are agreeable between them, but reimbursement cannot be in excess of the Rules. It is a violation of the Medical Fee Schedule for a provider to receive and retain, and for a payer to remit an amount above the Fee Schedule amount. Both the payer and the provider may be liable for a civil penalty of up to $10,000.00 each if a "pattern or practice" of payments in excess of the Medical Fee Schedule is found. The term "pattern or practice" is defined in Rule 0800-2-17-.03(61) of the definitions section in the Medical Cost Containment Program Rules and at the end of this section.

See Rule 0800-2-17-.01.

C. Clarification Regarding the 2005 Medicare "Floor" for Maximum Allowable Reimbursements under the Medical Fee Schedule

When calculating conversion rates for professional fees, the Medicare rate can not fall below 37.90 until 2007. This applies only to professional services. APC rates may decrease if Medicare lowers them, and the current OPPS APC Medicare amounts shall be used in calculating the maximum allowable amount under this Medical Fee Schedule. Changes in the RBRVS amounts for CPT codes may result in lower total Medicare allowable amounts for professional services at any time. However, the 2005 Medicare Conversion Factor of 37.90 shall not fall until 2007 at the earliest.

See Rule 0800-2-18-.02(2)(a).

D. Depositions

Procedure code 99075 must be used when billing for a deposition. The rate of maximum reimbursement for depositions is established in Division Rule 0800-2-16-.01. Licensed physicians may charge their usual and customary fee for providing testimony by deposition to be used in a workers' compensation claim, provided that such fee does not exceed seven hundred fifty dollars ($750) for the first hour's time. Depositions requiring over one (1) hour in duration shall be pro-rated at the licensed physician's usual and customary fee as set forth above, not to exceed four hundred fifty dollars ($450) per hour

for deposition time in excess of one (1) hour. Physicians shall not charge for the first quarter hour of preparation time. In instances requiring over one quarter hour of preparation time, a physician's preparation time in excess of one quarter hour shall be added to and included in the deposition time and billed at the same rates as for the deposition.

See Rule 0800-2-16-.01.

E. Usual and Customary under the Medical Fee Schedule

Many medical services under our Medical Fee Schedule are capped at the "usual and customary" amount. This usual and customary amount is defined in Rule 0800-2-17-.03(80). Quite simply, the usual and customary amount means 85% of the billed charges.

F. Out-of-State Medical Services

The Tennessee Medical Fee Schedule Rules apply whenever an injured employee is receiving workers' compensation benefits under Tennessee law or would be entitled to receive benefits under Tennessee law, whether the treatment is in Tennessee or any other state.

See Rules 0800-2-17-.01.

G. Adjustments to Bills

Recoding can not be used for cost containment. Recoding may only be used for the correction of miscoded services. Whenever there is any dispute concerning coding, the provider **must be notified** immediately and given an opportunity to appeal.

Any other recoding or so-called "down-coding" shall be a violation of the Medical Fee Schedule Rules. Because this practice is a violation of the Medical Fee Schedule, it will be penalized as such if this practice is found by the Department.

See Rule 0800-2-17-.03(2).

H. Charges for Medical Reports

Consistent with the statute governing these transactions, a provider may charge up to $10.00 for a medical report of twenty pages or less, and charge $0.25 per page for additional pages, so long as it is a complete medical report. However, submission of an office note is NOT considered a medical report and no compensation may be charged for submission of such documentation when needed for the payer to make determinations concerning treatment plans and payments. Providers should not charge for progress reports for follow up visits.

Charging for a medical report when simply providing progress reports (even if a copy of a prior medical report is included) to a payer to make determinations concerning payment and treatment plans is a violation of the Medical Fee Schedule and such violations will be penalized. Providers may not charge for completing a medical report form required by the Division.

If requested to do so, a provider must submit a complete C-32 Form within two (2) weeks of such request. The physician may charge up to one hundred fifty dollars ($150.00) for completing this form. *See* Rule 0800-2-1-.16.

See Rules 0800-2-17-.15, 0800-2-17-.16 and 0800-2-1-.16.

I. Missed Appointments

If an appointment is scheduled by the employer, carrier, or a case manager representing a carrier or employer, a provider may charge up to the amount of the basic office visit amount for a missed appointment. Missed appointments should be billed with the 99199 code, but an explanation of what would have been done with appropriate CPT codes should accompany the bill. Whatever was authorized may be charged and paid at the Medical Fee Schedule conversion factor amounts. This includes physical therapy; the modalities up to four can be billed if they were approved and would have been rendered.

See Rule 0800-2-17-.14.

J. Payment

Carriers must provide an explanation of medical benefits to the health care provider whenever the carrier's reimbursement differs from the amount billed. A carrier must date-stamp medical bills and reports upon receipt.

Any carrier that fails to pay an undisputed and properly submitted bill or the portion of that bill which is undisputed within thirty-one (31) calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% annual percentage rate) which is paid to the provider.

If a provider submits a bill on an improper form, the carrier has 20 calendar days of receipt of the bill to return it. The days between the date the carrier returns the bill and the date the carrier receives the corrected bill shall not apply towards the thirty-one calendar days the carrier has to pay the bill.

Providers **shall not** attempt to collect the balance of a bill from the injured employee.

Prepayments are prohibited by Rule 0800-2-17-.10(5).

See Rule 0800-2-17-10.

K. Utilization Review

Utilization review is required on outpatient cases in which the cumulative medical costs exceed $5,000. Utilization review is required in the form of pre-admission review for all inpatient admissions, and concurrent review should be done through discharge.

Utilization review is required on all prescribed physical and occupational services prior to such services being authorized by the carrier. In order to facilitate expedited utilization review, whenever a physician orders PT or OT the physician should include the diagnosis on the prescription for PT or OT. The initial utilization review may certify up to six (6) visits; utilization review is then required after each six (6) visit increment.

Utilization review is required for psychological treatment services in excess of fifteen (15) visits.

In all cases, notification of a determination by the utilization review agent must be communicated within two (2) business days of receipt of the request for determination and the receipt of all information necessary to complete the review.

See Rules 0800-2-17-.20, 0800-2-18-.09 and 0800-2-18-.14.

L. Penalties for Violations

Under the Medical Fee Schedule, civil penalties may be assessed by the Commissioner, at his discretion, up to $10,000.00. Although the Fee Schedule became effective July 1, 2005, these penalty provisions did not become effective until January 1, 2006, and will not be retroactive, that is, they are not applicable to violations pre-January 1, 2006.

See Rules 0800-2-17-.01(1), 0800-2-17-.13, 0800-2-.02(b)4. & 5. and 0800-2-18-.15.

M. Miscellaneous

The MFS is code specific in that the appropriate conversion factor to use is determined by the type of CPT code for the procedure, such as surgery, radiology, evaluation and management, etc. The AMA CPT guides should be used when determining if a code is surgical or medical.

All physicians' office visits are paid up to a maximum of 160% of the national Medicare amount, regardless of specialty. Physician's Assistants and Nurse Practitioners may be reimbursed up to a maximum of 100% of the national Medicare amount.

N. Administrative Appeals and Disputes Regarding Reimbursement

Whenever a disagreement exists between a payer and provider regarding a request for either the recovery of payment or for the full payment, either party may send the issue to the Medical Care and Cost Containment Committee for administrative review and a

recommendation. Also, disputes as to the application or interpretation of the Medical Fee Schedule Rules may be submitted to the MCCCC for review.

All requests for administrative review by the MCCCC must be sent to: Medical Director of the Division of Workers' Compensation, Tennessee Department of Labor & Workforce Development, 710 James Robertson Parkway, Andrew Johnson Tower, 2nd Floor, Nashville, TN 37243.

See Rules 0800-2-17-.21 and -.22.

III. TENNESSEE MEDICAL FEE SCHEDULE: MEDICAL SERVICES

A. Anesthesia Services

Anesthesia is paid up to a maximum of the usual and customary amount, which is 85% of billed charges. This is only applicable for anesthesia CPT codes, and does **NOT include** pain management services reimbursed under surgical codes (maximum reimbursement up to 200% of the national Medicare amount), or other injections, which are covered below under the Injections section.

See Rule 0800-2-18-.05.

B. Injections

Reimbursement for injections is allowed for both the administration of the drug (the actual injection) and the drug at Average Wholesale Price ("AWP".) However, certain codes include both the drug and the administration fee. In such cases, there shall be no additional administration or injection fee. If a J code is billed for the drug, it should be paid at 100% of Medicare. If there is no J code amount for the drug, it can not be paid at U&C. The drug must then be paid at AWP.

See Rule 0800-2-18-.06.

C. Home Healthcare

These services may be paid up to a maximum of the usual and customary amount, which is 85% of billed charges.

See Rule 0800-2-18-.02(4)(a).

D. Skilled Nursing Facility Charges

Because there is no specific amount set in the Medical Fee Schedule for these services, the maximum allowable amount is 100% of the national Medicare amount, or usual and customary, if no Medicare amount is listed.

See Rule 0800-2-18-.02(2)(a).

E. Outpatient Services (Including Emergency Room Care if Patient is Not Admitted)

Payment for outpatient services is based on the Medicare model known as the Outpatient Prospective Payment system or "OPPS." Under the Fee Schedule, physicians are paid separately for their professional services using the appropriate conversion factors set out in Rule 0800-2-18-.02(4) of the Medical Fee Schedule Rules. Charges for the facility at which the procedures are performed, such as the hospital or ambulatory surgical center ("ASC"), are paid separately. The maximum amount for facility charges may be found in most cases in a spreadsheet available at the Centers for Medicare and Medicaid Services' also known as "CMS'" website, http://www.cms.hhs.gov/HospitalOutpatientPPS or at the current CMS website which may replace this site. There are no adjustments made to this national Medicare amount for geographic area or wage/price indices. Should the billed charges be less than this amount, then they are the maximum that may be paid. If there is no amount listed for the procedure performed, then the maximum that may be paid is the usual and customary amount, which is 85% of the bill. When a bill contains both a procedure for which Medicare lists the amount and a procedure for which there is no Medicare amount, the unlisted procedure should be paid at 85% of the surgical charge. The listed procedure is paid at 150% of the Medicare unadjusted amount. The lesser of the two separate and distinct surgical procedures should be paid at 50% of the maximum allowable, except when status indicator "S" is designated.

Technical components for radiology when done in an ASC or hospital outpatient will be paid at 150% of Medicare, but may only be broken out when the Medicare APC code does not include it.

Medicare Outlier calculations are not recognized under the Tennessee Workers' Compensation Medical Fee Schedule.

See Rule 0800-2-18-.07.

F. Pathology Services

The maximum allowable amount for all pathology services, **no matter where performed**, is usual and customary, that is, 85% of billed charges. This includes MROs and any Diagnostic Facilities or Urgent Care Facilities.

All post-injury drug screens must be paid in accordance with the Medical Fee Schedule Rules. These procedures have a maximum allowable amount of usual and customary, which is 85% of the bill. Drug screens not related to a workers' compensation injury, such as pre-employment screening, are not subject to the Fee Schedule Rules.

See Rule 0800-2-18-.02(a).

G. Radiology Services

All non-ASC, non-hospital radiology (those done in a physician's office) may be reimbursed up to a maximum of 200% of the national Medicare amount for both the technical and professional fees. This includes all Diagnostic Facilities and Urgent Care Facilities.

See Rule 0800-2-18-.02(a).

H. Chiropractic Services

Chiropractic services are capped at 130% of the unadjusted national Medicare allowable amount. No charges are allowed for hot or cold packs, nor may a fee be charged for modalities in excess of four modalities per day. The definition of modality is the same as that used under Medicare. All physical therapy procedures performed by any chiropractor must be pre-certified through UR just as any other physical or occupational therapy services are under the PT/OT Rule, 0800-2-18-.09.

See Rules 0800-2-18-.08 and 0800-2-18-.09.

I. Physical Therapy/Occupational Therapy (PT/OT)

Currently, there are certain restrictions on physical therapy and occupational therapy in regards to two elements. First, there is a prohibition on so-called "self-referrals" by a treating physician to a facility in which she or he has any financial interest, known in our rules as a physician-affiliated facility. There is an exception to this prohibition, however. If the physician is board-certified in one of four medical specialties, Neurology, Orthopedics, Occupational Medicine or Physiatry, then they may self-refer. There is also an exception if there is no other facility within a fifteen (15) mile radius of the employee's home or work.

If a physician self-refers a claimant for P.T., the claimant has a right to go somewhere else for physical therapy other than to the physician's facility. This is intended to allow the patient a choice to attend a non-physician affiliated physical therapy facility.

Physical therapy requires pre-certification before the first visit and after every 6 visit increment of services. In order to facilitate expedited utilization review, whenever a

physician orders PT or OT, the physician should include the diagnosis on the prescription for PT or OT.

Pre-certification for physical therapy of inpatients is covered under the utilization review requirement to concurrently review inpatient admissions through discharge. You should also consult the Utilization Review section of this booklet for additional information concerning these requirements.

Functional Capacity Evaluations ("FCEs") are reimbursable up to a maximum of usual and customary that is, 85% of the billed charges. **FCEs are NOT subject to UR and the pre-certification requirements.**

The number of PT/OT visits count does not restart for any reason other than surgery.

See Rule 0800-2-18-.09.

J. Speech Therapy

Speech therapy services should be paid on the same sliding scale as physical therapy.

See Rule 0800-2-18-.09.

K. Durable Medical Equipment and Implant Reimbursement

Durable medical equipment ("DME") and implants for which billed charges are $100.00 or less are capped at 85% of those charges. For DME and implants over $100.00, the maximum allowable is the manufacturers' invoice amount plus fifteen percent (15%) of invoice, with the 15% capped at a maximum of one thousand dollars ($1,000). This calculation is per item and is not cumulative. The payer may request a copy of the invoice for payment, but it is not required unless there is such a request. Implants used in an outpatient setting are treated specially. Consult Rule 0800-2-18-.07 for specifics.

Hearing aids are considered DME if no customization is needed. However, if they are customized, i.e., molded and fitted to the individual, then they should be considered under this Orthotics and Prosthetics section, and reimbursed accordingly.

See Rules 0800-2-18-.07 and 0800-2-18-.10.

L. Medical Supplies

In all cases, Medical Supplies shall be reimbursed pursuant to applicable Medicare guidelines. Items such as casts and the like should be paid under the appropriate codes, such as Q codes in that particular case.

See Rule 0800-2-17-.05.

.M. Orthotics and Prosthetics

These devices are capped at 115% of the national Medicare allowable amount. Hearing aids are considered DME if no customization is needed. However, if they are customized, i.e., molded and fitted to the individual, then they should be considered under the Orthotics and Prosthetics section, and reimbursed accordingly.

See Rule 0800-2-18-.11.

N. Pharmacy

Prescribed drugs are capped at the lesser of: the provider's usual charge; a negotiated contractual amount; or, the average wholesale price ("AWP") plus a $5.10 Filling Fee under the Fee Schedule. If the actual charge is less than this amount, then it is the maximum allowed. Physicians dispensing drugs from their office do not receive the additional $5.10 filling fee. A compounding fee no higher than $25.00 is allowed per compound prescription if two or more prescriptive drugs require compound preparation when sold by a hospital, pharmacy, or a provider other than a physician.

Generally, an injured employee should receive only generic drugs or single-source patented drugs for which there is no generic equivalent unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription "dispense as written" or "no substitution allowed" in the prescriber's own handwriting. Should an injured employee wish to receive brand name drugs when a generic is available, she or he may do so at their own expense.

Pharmacists may charge up to the usual and customary amount for over-the-counter non-prescription drugs. No Filling Fee is allowed for these non-prescription drugs.

See Rule 0800-2-18-.12.

O. Ambulance Services

Pre-certification is required for all ground and air ambulance services that are non-emergency. When it is an emergency, retro-certification is required within 72 hours of service, or within three business days. Reimbursement for these services is capped at the lesser of the billed charges, or the average rate paid for ambulance services within the same geographic area.

See Rule 0800-2-18-.13.

P. Clinical Psychological Services

Psychological treatment by any clinician other than a licensed psychiatrist is capped at 100% of the national Medicare allowable amount. Utilization review is required for all psychological treatment services in excess of fifteen (15) visits.

See Rule 0800-2-18-.14.

Q. Surgery, Surgical Assistants and Modifiers

Physicians performing surgery may generally receive up to 200% of the allowable unadjusted national Medicare amount. Board-certified, and physicians eligible for board-certification, in either neurological surgery or orthopedic surgery may receive up to 275% of this Medicare amount for surgical services only.

A physician who assists at surgery may be reimbursed up to the lesser of the surgical assistant's usual charge or twenty percent (20%) of the maximum allowable Medical Fee Schedule amount. Licensed physician assistants may serve as surgical assistants but shall be limited in reimbursement to the fee due from the procedure as calculated pursuant to Medicare guidelines, not the conversion factors contained in the Workers' Compensation Medical Fee Schedule.

Modifiers should be used in a manner consistent with Medicare Guidelines and Procedures. Modifier 22, in accordance with Medicare principles, should only be used when a case is clearly out of the range of ordinary difficulty for that type of procedure. Using the example of gallbladder surgery, if a patient weighed 300 pounds and had previous upper abdominal surgery such that adhesions in the upper abdomen were extremely dense, the gallbladder was densely adherent to the gallbladder bed on the liver, and the surgery time was two and one-half hours, that would be a case where the surgeon is justified in using the -22 modifier and asking for extra reimbursement beyond the usual Medicare fee schedule amount.

When a claim is submitted with the -22 modifier, it must be clearly evident why extra reimbursement is being sought. There must be two separate pieces of documentation submitted with a claim on which the -22 modifier has been appended. First, there must be a copy of the surgeon's operative note. The operative note must clearly document the unusual difficulty of the case. The time that the case took should be documented in the operative note and it is helpful if the time a usual case takes is listed for comparison. Again, using the unusual case of gallbladder surgery above, the surgeon might report at the end of the operative note, after describing the very difficult dissection, that the operation took two and one-half hours, with the usual operation time being one hour and 15 minutes.

Second, there must be a separate letter from the surgeon, explaining why extra reimbursement is being requested. Finally, these two documents should be congruent, which is to say that the letter should not describe a terribly difficult procedure while the operation note describes a standard case. These two separate pieces of documentation are required because they are needed to:

- show that an unusually difficult procedure was indeed performed; and,
- allow determination of what level of extra payment above the usual Fee Schedule amount should be allowed.

If a procedure is submitted with a -22 modifier appended to it and can be allowed for payment, but the two required pieces of documentation are not submitted with the claim, the claim should be paid up to the normal Fee Schedule amount without any extra allowance.

The maximum allowable additional amount under the Fee Schedule for Modifier 22 is 10%.

See Rules 0800-2-18-.04 and 0800-17-.07.

R. Professional Services

Maximum allowable fees for professional services should always be calculated using the Medical Fee Schedule Rules' conversion factors set forth in Rule 0800-2-18-.02(4)(a).

Example: CPT code 99204 --- Office/outpatient visit, new patient – Total non-facility RVUs = 3.62. This is a general medicine code, actually an evaluation and management code, so the maximum allowable amount is 160% of the national Medicare amount, which results in a monetary conversion factor of $60.64. So 60.64 x 3.62 units = $219.52. Thus, the maximum allowable for this CPT code is $219.52.

Example: CPT code 25444 ---Reconstruct wrist joint – Total facility RVUs = 21.90. This is a surgery code, so the maximum allowable amount is 200% of the national Medicare amount (unless the surgeon is a board-certified or board-eligible neurosurgeon or orthopedic surgeon, in which case the maximum allowed is 275% of national Medicare), which results in a monetary conversion factor of $75.80. So 75.80 x 21.90 units = $1,660.02. Thus, the maximum allowable for this CPT code is $1,660.02.

See Rule 0800-2-18-.02.

S. Dentistry

Dental services are capped at 100% of the allowed national Medicare amount, with no adjustments for geographic index or wage/price index. If there is no appropriate Medicare amount (as there are not in many instances), then the maximum amount allowed under the Medical Fee Schedule is the usual and customary amount, which is 85% of the billed charges.

See Rules 0800-2-18-.02(2)(a) and 0800-2-18-.02(4)(a).

T. Physician's Assistants and Certified Nurse Practitioners-Maximum Reimbursement

In accordance with a recent opinion by the Tennessee Attorney General, physician assistants and certified nurse practitioners may provide treatment within the scope of their licensure under the direct orders of the treating physician, and the workers' compensation

patient need not be seen by the treating physician on each visit. Maximum reimbursement for these professionals is 100% of the national Medicare allowable amount for these types of professionals. In no event shall reimbursement be based on a physician's office visit if the patient is seen only by a physician's assistant or nurse practitioner.

See Rule 0800-2-17-.05(4).

IV. IN-PATIENT HOSPITAL FEE SCHEDULE

The In-patient Hospital Fee Schedule, Chapter 0800-2-19, is applicable for all ***inpatient*** hospital stays. These are defined as hospital stays which exceed 23 hours. Different rules apply for outpatient services performed in a hospital setting. For these see Rule 0800-2-18-.07.

See Rule 0800-2-19-.02(6).

A. In-patient Hospital Services Are Reimbursed under a Per Day Methodology

In-patient services are calculated under a per day or "*per diem*" basis, not under the Medicare DRG system. This is one of the areas in which the Tennessee Medical Fee Schedule differs from the Medicare basis used throughout most of the Fee Schedule Rules.

Reimbursement for a compensable workers' compensation claim **shall be the lesser of the hospital's usual charges, the PPO or other contracted amount, or the maximum amount** allowed under this In-patient Hospital Fee Schedule.

In-patient hospitals are grouped into the following separate peer groupings:

1. Peer Group 1 Hospitals

2. Peer Group 2 Rehabilitation Hospitals

3. Peer Group 3 Psychiatric Hospitals

See Rule 0800-2-18-.02(2)(b) and 0800-2-19-.01.

B. Maximum Allowable Reimbursement Amounts

The maximum *per diem* rates to be used in calculating the reimbursement rate is as follows:

Surgical Admissions - $1,800.00 for the first seven (7) days; $1,500.00 per day for each day thereafter. This includes Intensive Care (ICU) & Critical Care (CCU);

Medical Admissions - $1,500.00 for first seven (7) days; $1,250.00 per day for each day thereafter;

Rehabilitation Hospitals - $1,000.00 for the first seven (7) days; $800.00 per day thereafter;

Psychiatric Hospitals (applicable to chemical dependency as well) maximum allowable amount is $700.00 per day.

C. Trauma care

Trauma care at any licensed Level 1 Trauma Center **only** shall be reimbursed at a maximum rate of $3,000.00 per day for each day of patient stay. Actual trauma care determines trauma rates for admissions and re-admissions. The person must have required admission or re-admission to a trauma center and the person could not have been treated in a non-trauma facility. Trauma must be the primary diagnosis.

Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate *per diem* rate, or the hospital's billed charges minus any non-covered charges.

A list of all trauma centers in the state may be accessed at this website: http://www2.tennessee.gov/health/ems/TraumaCenterInspections.htm

D. Surgical implants

These shall be reimbursed separately and in addition to the *per diem* hospital charges pursuant to Rule 0800-2-18-10 of the Medical Fee Schedule Rules.

Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). Maximum reimbursement for implantables billed at $100.00 or less per item shall be limited to eighty-five percent (85%) of billed charges. Maximum reimbursement for implantables over $100.00 is limited to the hospital's cost plus fifteen percent (15%) of the invoice amount, up to a maximum of invoice plus $1,000.00 per item. This is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables which have an invoice amount over $100.00 shall be accompanied by an invoice.

E. Non-covered charges

Non-covered items are: convenience items, charges for services not related to the work injury/illness services that were not certified by the payer or their representative as medically necessary.

F. Amounts in Addition to Per Diem Charges

The following items **are not included in the *per diem* reimbursement** to the facility and may be reimbursed separately. All of these items must be listed with the applicable CPT/HCPCS codes.

Durable Medical Equipment --- Items $100.00 or less, the maximum amount is 85% of billed charges; over $100.00, the maximum amount is the manufacturer's invoice amount plus 15% of invoice, with the 15% capped at $1,000.00. This is NOT cumulative, but is per item.

Orthotics and Prosthetics --- capped at 115% of the national Medicare allowable amount.

Implantables --- Items $100.00 or less, maximum is 85% of billed charges; over $100.00, the maximum amount is the manufacturer's invoice amount plus 15% of invoice, with the 15% capped at $1,000.00. This is NOT cumulative, but is per item.

Ambulance Services --- capped at the lesser of the billed charges, or the average rate paid for ambulance services within the same geographic area.

Take-home Medications and Medical Supplies --- Over-the-counter medications may be reimbursed up to the usual and customary amount, 85% of billed charges. Prescription drugs are reimbursable up to the lesser of the normal charge for the drug, or the AWP fee. Medical Supplies shall be reimbursed pursuant to current Medicare guidelines up to 100% of the Medicare allowable amount.

Radiology Services --- maximum is 200% of national Medicare amount.

Pathology Services --- maximum is the usual and customary amount, which is 85% of billed charges.

The above-listed items are reimbursed in accordance with the Medical Cost Containment Program Rules (Chapter 0800-2-17) and Medical Fee Schedule Rules (Chapter 0800-2-18) payment limits. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-2-17-.03(80), unless otherwise indicated in the Medical Fee Schedule Rules. In-patient hospital *per diem* rates are all inclusive (with the exception of those items listed above).

G. Reimbursement Calculations Explanation:

1. Each admission is assigned an appropriate DRG.

2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission.

3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission.

Reimbursement Formula: LOS X SPDA = WCRA

Example: DRG 222: Knee Procedures W/O CC
Hospital Peer Group: 1-Surgical admission:
Maximum rate per day: $1,800 first seven (7) days/$1,500 per day each day thereafter
Number billed days: 9
Billed charges: $15,600
Maximum Allowable Payment: $15,600

See Rule 0800-2-19-.03.

H. Stop-Loss Method

Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least $15,000. Amounts for items set forth in rule 0800-2-19-.03(d)(4.), such as implantables, radiology, pathology services, DME, etc., **shall NOT be included in determining the total Allowed Charges for stop-loss calculations**.

This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

The stop-loss formula: (Additional Charges x SLRF) + Maximum Allowable Payment = WCRA

Example: DRG 222: Knee Procedures W/O CC
Hospital Peer Group: 1 – Surgical admission
Maximum rate per day: $1,800 for first 7 days; 1,500 for 2 additional days
Number Billed Days: 9
Total Billed Charges (**minus amounts for implants, radiology, etc**.): $53,650.00
Maximum allowable payment for Normal DRG stay.....$15,600.00
Versus: billed charges $53,650.00
Amount Payable Before Stop-Loss,
Lower of Charge vs. Maximum Allowable..... $15,600.00
Total difference, charges over and above maximum payments $38,050.00

Difference over and above $15,000 Stop-loss is..... $23,050.00
Payable under Stop-loss (80% of $23,050.00)..... $18,440.00
Amounts due hospital for implants.....$3,525.00
Total Payment
Due Hospital: ..... 15,600 + 18,440.00 + 3,525.00 = $37,565.00

See Rule 0800-2-19-.03(4).

I. Pre-admission Utilization Review

Payers shall be liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subparagraph (g) of this Rule required to treat a compensable injury, when any of the following situations occur:

The treating doctor, his/her designated representative, or injured employee has received approval after utilization review from the carrier prior to the health care treatments or services, the carrier has failed to communicate approval or denial of the healthcare treatment or services within seven (7) business days of a provider's request for utilization review and approval; or, when ordered by the Division.

Payers must designate an accessible direct telephone number, and may also designate a facsimile number for use by the provider or the provider's designated representative or the injured employee to request utilization review and approval during normal business hours. The direct number shall be answered or the facsimile responded to, by the carrier's agent delegated to approve or deny requests, within the time limits established in this Fee Schedule.

Prior to the date of proposed treatment or services, the provider or the provider's designated representative, shall notify the insurance carrier's delegated agent, by telephone or transmission of a facsimile, of the recommended treatment or service listed in this Fee Schedule. Notification shall include the medical information to substantiate the need for the treatment or service recommended. If requested to do so by the carrier, the treating doctor shall also notify the insurance carrier of the location and estimated date of the recommended treatment or service, and the name of the health care provider performing the treatment or service, if other than the provider. Designated representative includes, but is not limited to, office staff, hospitals, etc.

Within seven (7) business days of the provider's request for utilization review and approval, the insurance carrier's delegated agent shall notify the provider or the provider's designated representative, by telephone or transmission of a facsimile, of the insurance carrier's decision to grant or deny. Failure of the carrier to communicate its approval or denial within seven (7) business days of a provider's request shall automatically be deemed an approval of the request. When the insurance carrier approves, the insurance carrier shall send written approval, or if denying, shall send documentation identifying the reasons for denial. Notification shall be sent to the injured employee, the injured employee's representative if known, and the provider or the

provider's designated representative, within 24 hours after notification of denial or approval.

Payers must maintain accurate records to reflect information regarding the utilization review request and approval/denial process.

If a dispute arises over denial by the insurance carrier, the doctor or the injured employee may file a Request for Assistance with a Benefit Review Specialist.
The health care treatments and services requiring pre-admission utilization review are: all non-emergency hospitalizations, cases in which the cumulative medical costs of the case have reached $5000.00 or more and non-emergency transfers between facilities.

See Rule 0800-2-19-.04.

J. Pharmacy Services

Pharmaceutical services rendered as part of in-patient care are considered inclusive within the In-patient Hospital Fee Schedule and shall not be reimbursed separately.

See Rule 0800-2-19-.05.

K. In-Patient Hospital Fee Schedule Definitions

In addition to the definitions set out in the Medical Cost Containment Program Rules, Chapter 0800-2-18, there are specific definitions provided in the In-Patient Hospital Fee Schedule Rules in Rule 0800-2-19-.02. These should be consulted to determine specific meanings of terms used in this Schedule.

L. Penalties for Violations of the In-Patient Hospital Fee Schedule

The same rules regarding payments in excess of the Medical Fee Schedule are applicable to this Fee Schedule.

See Rule 0800-2-19-.06.

M. Additional Information about the Medical Fee Schedule

More information on the Medical Fee Schedule is available in the Medical Fee Schedule Rules at our website, http://www.tennessee.gov/labor-wfd/wcomp.html , at the Tennessee secretary of state's website, http://www.tennessee.gov/sos/rules/0800/0800-02/0800-02.htm , or through the:

Tennessee Department of Labor and Workforce Development
Division of Workers' Compensation
710 James Robertson Parkway
Nashville, TN 37243
Phone: (615) 741-2395